CANNON BUILDING
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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION
BOARD OF MEDICAL PRACTICE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: WWW.DPR.DELAWARE.GOV

Verification of Medical Education

Institution:_____	Applicant Name:_____
Address:_____	Home Address:_____
City/State/Zip:	City/State/Zip:

This section is to be completed by applicant.

Be sure to sign the form.

Last Name:_____ First Name:_____

SSN:_____

DOB:_____

Name if Different from Above:_____

Signature: _____ Date: _____

Program Participation to be completed by the Institution:

Our records indicate that:

_____ was enrolled in our institution
(Type or print individual's name: Last, First, Middle)

during the following dates(mm/dd/yy)below:

	From	To
1st Year:	_____/_____/_____	_____/_____/_____
2nd Year:	_____/_____/_____	_____/_____/_____
3rd Year:	_____/_____/_____	_____/_____/_____
4th Year:	_____/_____/_____	_____/_____/_____

This individual (check one):

____ was awarded the degree of _____ on_____/_____/_____
(mm/dd/yy)

____ was **NOT** awarded a degree (please attach an explanation)

CERTIFICATION

*****AFFIX INSTITUTIONAL OR NOTARIAL SEAL HERE**

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Printed Name:_____ **Signature:**_____

Title:_____ **Date of Signature**_____

Tel: _____ **Fax:** _____ **Email:**_____

*****RETURN COMPLETED FORM WITH SEAL AFFIXED TO THE BOARD ADDRESS ABOVE. THANK YOU.**